Selected conditions of accessibility to health care services for asylum seekers and refugees in Poland against the indicated European initiatives

(Wybrane uwarunkowania dostępności do świadczeń zdrowotnych dla cudzoziemców ubiegających się o ochronę międzynarodową i uchodźców w Polsce)

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Abstract – Introduction. Increasing influx of migrants, including refugees and asylum seekers, started in 2015, poses significant challenges to the health care system and broadly understood public health institutions. Migration is seen as the most important public health challenge for the WHO of the European Region and on a global scale. The right to health services is one of the basic human rights and as such it should be implemented regardless of the legal situation of the person's.

The aim of the study. The main purpose of the study is to demonstrate the regulatory, organisational, political and cultural conditions of providing health care services and their scope for asylum seekers and refugees in Poland after the migration crisis of 2015.

Selection of material. The study is based on the literature review and legal regulations analyse. The literature review is partially resulting from a review developed in 2016 within the EC project SH-CAPAC ("Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure", nº 717175), with further findings for 2017-2019. Legal regulations include international and Polish laws.

Conclusions. Due to its geopolitical location Poland, being the transit country with specific approach to the refugees on the possible entry points, did not recorded the rapid increase in the number of immigrants seeking for international protection. Asylum seekers are granted access to health care services coordinated by a healthcare unit with had signed an agreement with the Office for Foreigners. Once the person receives the refugee status, his or her access to health services should be equivalent to that of the citizens of Poland. As the organisational and cultural conditions of providing health care for asylum seekers and refugees occur in the situation of limited number of asylum seekers and refugees the problem may become more significant in case of a rapid grow of number of involuntary immigrants.

Key words - asylum seekers, health care, migrants, refugees.

Streszczenie – Wstęp. Zwiększony napływ migrantów, w tym uchodźców i osób ubiegających się o azyl, rozpoczęty w 2015 r., stanowi poważne wyzwanie dla systemu ochrony zdrowia i szeroko rozumianych instytucji zdrowia publicznego. Migracja jest postrzegana jako najważniejsze wyzwanie zdrowia publicznego dla WHO Regionu Europejskiego i na skalę globalną. Prawo do świadczeń zdrowotnych jest jednym z podstawowych praw człowieka i jako takie powinno być realizowane bez względu na sytuację prawną danej osoby.

Cel pracy. Głównym celem badania jest przedstawienie uwarunkowań organizacyjnych, politycznych i kulturowych świadczeń zdrowotnych oraz ich zakresu dla osób ubiegających się o azyl i uchodźców w Polsce po kryzysie migracyjnym z 2015 roku.

Dobór materiału. Badanie opiera się na przeglądzie literatury i analizie regulacji prawnych. Przegląd literatury częściowo wynika z przeglądu opracowanego w 2016 r. w ramach projektu SH-CAPAC („Wsparcie krajów członkowskich UE w zakresie koordynacji, oceny, planowania i dostępu do opieki zdrowotnej w związku ze szczególnym naciskiem migracyjnym", umowa z KE nr 717175), z kontynuacją dla lat 2017-2019. Regulacje prawne obejmują prawo międzynarodowe i polskie.

Wnioski. Ze względu na swoje położenie geopolityczne Polska, będąc krajem tranzytowym ze szczególnym podejściem do uchodźców na granicy, nie odnotowała gwałtownego wzrostu liczby imigrantów ubiegających się o ochronę międzynarodową. Osoby ubiegające się o azyl mają dostęp do usług opieki zdrowotnej koordynowanych przez jednostkę opieki zdrowotnej, która podpisała umowę z Urzędem ds. Cudzoziemców. Gdy dana osoba otrzyma status uchodźcy, jej dostęp do usług zdrowotnych powinien być równoważny z dostępem obywateli Polski. W chwili obecnej warunki organizacyjne i kulturowe świadczenia opieki zdrowotnej dla osób ubiegających się o azyl i uchodźców

występują w ograniczonej liczebnie grupie; problem ten może stać się bardziej znaczący w przypadku szybkiego wzrostu liczby przymusowych imigrantów.

Słowa kluczowe – opieka zdrowotna, migranci, uchodźcy, osoby ubiegające się o azyl.

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B. Gathering and listing data
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I. INTRODUCTION

Increasing influx of migrants, including refugees and asylum seekers, started in 2015, poses significant challenges to the health care system and broadly understood public health institutions. Migration is seen as the most important public health challenge for the WHO of the European Region [1] and on a global scale ([2]. No one knows the exact number of international migrants [3]; their number in 2017 was estimated at 257 million [4], the number of refugees in 2016 was estimated at 22.5 million [5] to 25.9 million [6]. At the same time, there is an increase in migration trends, including an increase in the number of refugees[1], caused both by inter-state conflicts and domestic conflicts. In EU countries there are the different definitions of "migrant", "refughee", "asylum seeker" used in official language and practice. The latest literature also draws attention to the situation of environmental (climate) refugees (migrants) - the population affected by climate change (increasing the level of the seas and oceans, desertification, increase in the frequency of natural disasters), although in this case they are not always international migrations. On the one hand, climate migrants, although being forced migrants, do not meet the condition set out in the European directive to obtain refugee status - this is not a situation of "being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group" [8]. On the other hand, it is difficult to recognize that, similarly to economic migrants, they voluntarily decide to leave the endangered areas. Thus, both extreme weather events and gradual changes in weather patterns resulting from global warming that may lead to food and water shortages and loss of livelihoods (land degradation, deforestation and rising sea and ocean levels); violence, political oppression and violations of human rights as well as people's desires for a better life and greater economic opportunities constitute and will continue to be a source of forced or voluntary migration [9]. In all cases of involuntary migration, host countries must address the issue of potential exclusion of asylum seekers and refugees from the group of persons entitled to benefits and their unmet health needs [2].

A separate category of migrants are irregular migrants, mentioned in this paper because of the close link between this group and other people seeking protection - as some asylum seekers may become irregular migrants – having escaped from the Centre for Foreigners or staying in Poland without the refugee status.

The main purpose of the study is to demonstrate the regulatory, organisational, political and cultural conditions of providing health care services and their scope for asylum seekers and refugees in Poland after the migration crisis of 2015.

II. SELECTION OF MATERIAL

The study is based on the literature review and legal regulations analyse. The literature review is partially resulting from a review developed in 2016 within the EC project SH-CAPAC ("Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure", nº 717175), with further findings for 2017-2019. Legal regulations include international and Polish laws.

[1] Both explicit separation of refugees as a separable category from migrants and the recognition of refugees as a special category of migrants, also known as political migrants, are found in the literature (cf. [7]).

III. PUBLIC OBLIGATIONS IN THE AREA OF HEALTH CARE FOR REFUGEES AND ASYLUM SEEKERS

As the effect of migration, challenges for societies receiving migrants and authorities emerge at various levels; integration programs are being introduced, and the possibilities of facilitating migrants' finding on the labour market or limiting such access, ensuring education of children, and adults are discussed. Moreover, the movement of large population groups leads to the emergence - or intensification - of challenges for the health care sectors in the provision of (appropriate) healthcare services for the incoming population. Although the number of refugees is a relatively small percentage of all migrants, they often require increased attention and actions due to their very difficult situation [10]. As a result of cultural, economic and legal barriers to access to services, immigrants tend to benefit from emergency care instead of prevention, which results in delayed detection of diseases and the inability to prevent them; for the host society, this means increased spending on health care [11]. A difficult issue is also the access of irregular migrants' to health services - advocates of limiting their access to services use, among others, financial arguments to support their point of view, however, research suggests that it is questionable that migrants' restriction on healthcare would be saving much for the health system [12]. The access of migrants or refugees to health services is not the only problem resulting from increased migratory movements - the next one is the migration of medical personnel, but this article focuses on migrants and refugees (including people applying for international protection) as potential patients.

Providing adequate care for migrants, including asylum seekers, is the subject of many activities and publications, describing, in particular, barriers to access to services[2]. From a broad perspective of public health, further areas of interest should be indicated: organization of culturally sensitive health care (including training of medical and administrative staff related to multiculturalism and strengthening their intercultural competences, raising awareness of differences in the health status of individual migrant groups and different needs, but also educational activities for patients in the languages and forms of communication they understand), health monitoring and disease reporting systems, screening, hygiene and sanitation (WASH), adequate (due to their health and religious beliefs) food, vaccinations, behaviour, mental health, violence (cf. [14]).

IV. POLITICAL CONDITIONS

Admitting migrants and providing them with adequate care must be discussed against the background of a specific political situation. Considering that the migration crisis began in 2015, the question may be asked whether the Polish authorities have ever shown a willingness or even a readiness to accept refugees at that time. In the literature referring to European countries that are the target of an increased influx of refugees, attention is drawn to the recent transition from „refugees welcome" to „migrants unwelcome", with all the long-term and ambiguity of this process [15], however in Poland the lack of initiatives taken by the authorities indicates the use of the "migrants unvelcome" attitude from the very beginning of the refugee crisis. In 2014 attention was paid in Poland to the systematic increase in the number of foreigners applying for international protection coming to Poland, treating this phenomenon probably as a constant trend [16]. However, in 2016-2017, the Polish authorities decided not to accept refugees on the basis of an earlier relocation agreement; in 2018 cases of asylum seekers being prevented from submitting applications for protection were observed.

Poland's Commissioner for Human Rights (Ombudsman) Adam Bodnar paid attention to this attitude of the Polish authorities, commenting on the next components of Polish migration policy, in particular with regard to global politics (for example, Poland's voting against the Global Compact for Safe, Orderly and regular Migration [18]). This attitude is highlighted when the number of potential applicants is artificially reduced by not allowing applications to be submitted at the border. Meanwhile, in the opinion of the Commissioner, every person declaring the desire (need) to be protected, should be admitted to Poland, and Border Guard officers are "obliged to accept the appropriate application from it" [19]. The Commissioner's position is based on the provisions of the Convention on the Status of Refugees [20].

The attitude of "migrants unwelcome" also concerned the possibility of participating in European programs concerning the support of European Union member states in the situation of increased inflow of migrants: MEM-TP ("Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma") and SH-CAPAC ("Supporting health coordination, assessments, planning,

[2] Cf. systematic revue within SH-CAPAC project, showing a sharp increase in the number of publications in 2012-2016 [13]

access to health care and capacity building in Member States under particular migratory pressure"). The tools developed as part of the SH-CAPAC project were piloted in several EU countries, but not in Poland due to the lack of interest from the relevant central authorities. Initial interest in project work and piloting was demonstrated by representatives of local self-government, however, due to organizational difficulties, this interest did not turn into concrete effects in the form of cooperation. Special interest in the subject of barriers in access to benefits for migrants was demonstrated by the City Council of Gdańsk, developing in 2015-2016 the Model of Integration of Immigrants [21]. Further initiatives were undertaken also by the councils of other cities, together with NGO's, e.g. in Kraków, Lublin.

V.CULTURAL CONTEXT OF PROVIDING HEALTH SERVICES TO IMMIGRANTS

Cultural differences in the perception of the other person can lead to many problems in the care of the patient from outside the native cultural area [22]. The cultural context is highlighted in several aspects. First of all, there are indications of existing or anticipated barriers to the access of migrants, including refugees, but also national and ethnic minorities to healthcare services of adequate quality. The further the country of origin is and a smaller group of immigrants originating from a given region, the greater is the likelihood of misunderstandings with the medical staff [23]. Secondly, cultural psychology says that cultural differences influence the assessment of a patient's health through the prism of the doctor's knowledge, which is also not free of cultural factors [7]. Moreover, the way of fulfilling the professional role of a doctor or nurse can be varied depending on the cultural environment [24]. The influence of culture on the occurrence of specific diseases and on treatment as well as on diagnostics is described [25]. Finally, the perception and assessment of medical procedures is culturally diverse [26].

Cultural barriers can be considered as the most challenging in providing services of adequate quality, due to their interdisciplinary character and relations. Working on the improvement in this area, the system would need to focus on sociological, psychological aspect of intercultural relations as well as on the education and training of both, patients and medical and administrative staff. In general, Poles are not open to accepting refugees from countries affected by armed conflicts, although the tendency to provide them with at least temporary shelter depends on which country they come from [27]. The migration crisis has exacerbated fears and opposition to the further settlement of refugees arriving in Europe, expressed in prejudice and stereotyping of the image of the newcomers, also in Poland [28].

VI. ACCESS AND ORGANISATION OF HEALTH SERVICES FOR REFUGEES – EUROPE'2016 INITIATIVES

Providing health care services for a specific group, such as refugees and asylum seekers, requires attention to issues of quality and equality, particularly important in the face of cultural or linguistic barriers existing on the line health care provider - the (potential) beneficiary. The starting point are human rights, which are referred to, inter alia, the United Nations documents on migrants and refugees (New York Declaration on refugees and migrants [29], Global Compact for Refugees [30], Global Compact for for Safe, Orderly and Regular Migration [18]). The right of access to healthcare is protected in several international human rights instruments. For example, the Charter of Fundamental Rights of the European Union states that 'everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices' [31] while the United Nation's International Covenant on Economic, Social and Cultural Rights identifies 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'

In practice, however, legal status has proved to be one of the main formal barriers to migrants' access to healthcare. In many EU Member States, undocumented migrants are only able to access emergency healthcare, which is not always granted free of charge. The European Union Agency for Fundamental Rights (FRA) and stakeholders such as the Platform for International Cooperation on Undocumented Migrants (PICUM) argue in favour of indiscriminate access to primary and preventive healthcare. In their 2014 [32] and 2015 reports [33], FRA and PICUM contend that not giving undocumented migrants timely access to screening and treatment, but treating conditions only when they become an emergency, may not only endanger their individual health, but could also be detrimental to public health and result in a greater economic burden to healthcare systems, since providing health services through emergency care is more costly. The health strand of the

Migration Integration Policy Index (MIPEX) 2015, a tool for measuring policies to integrate migrants in EU Member States and several other countries, indicates major differences in terms of migrants' healthcare coverage and ability to access services [34].

It should be remembered that even for its own citizens, the European Union imposes restrictions on the right to freely acquire planned treatment outside their country of residence. The rights arising from so-called cross-border care guarantee the freedom of choice of the health care provider on the EU market in open care. Hospital care requires authorisation for such treatment from the institution responsible for financing health services in the country of origin [35].

The abrupt increase in the number of immigrants in Europe mentioned above, among other things, increased the interest of European institutions, including EU, possible response scenarios, which resulted in the announcement of further calls to support national systems in the face of a new challenge. „Third EU Health Programme (2014-2020) Specific Project Grants for Horizontal Actions (HP-HA-2015): Support Member States under particular migratory pressure in their response to health related challenge" [36] resulted in granting financing to five winning consortiums. A brief summary of the objectives of the programs financed from the European Commission's budget in 2016 is presented in the table 1.

The details of programs aimed at improving access to services for various types of migrants, including refugees, refer to concepts such as patient-oriented care and cultural sensitivity. Supporting activities proposed in support programs concern, inter alia, estimation of health needs (especially in the field of mental health), care for migrants / particularly sensitive refugees (e.g. unaccompanied children, elderly people, disabled), coordination of public administration activities, designing cooperation models, development of training programs for the management and representatives of medical professions.

Table 1. List of European projects financed in 2016 selected within the call "Support Member States to migratory pressure in their response to health related challenges"[37]

Acronym	Full name	Coordinator	Main area
EUR-HUMAN	European Refugees - Human Movement and Advisory Network	University of Crete, Greece	Defining, designing and evaluating interventions aimed at developing integrated human-centred interventions for the provision of primary health care to refugees and other migrants
SH-CAPAC	Supporting health coordination, assessment, planning, access to health care and capacity building	Andalusioan School of Public Health, Spain	Support EU Member States under migratory pressure in coordination, estimation of needs, planning responses to health related challenges
8 NGOs in 11 States	8 NGOs for migrants/refugees' health needs in 11 countries	Doctors of the World; France[3]	Supporting health authorities in providing adequate and acessible health services to newly arrived migrants
CARE	Commmon Approach for REfugees and other migrants' health	National Institute for Health, Migration and Poverty, Italy	Promoting a better understanding of refugees and migrants' health condition and supporting the adaptation of the appropriate clinical attitude towards refugees and migrants' health needs
RE-HEALTH	Support Member States under particular migratory pressure in their response to health related challenges	International Organisation for Migration[4]	Improving the capacity of EU Member States under migratory pressure to address the health-related issues of arriving migrants

VII.HEALTH CARE FOR ASYLUM SEEKERS IN POLAND

The constitutional basis of protection granted to foreigners in Poland is Article 56, pursuant to which, firstly, foreigners may use asylum in the Republic of Poland, and secondly - a foreigner who is seeking protection against persecution may be granted refugee status [38]. Asylum seekers and refugees become subjects "under the authority of the Republic of Poland" and therefore "enjoy the freedoms and rights provided in the Constitution" especially those referring to "everyone", however, exceptions provided by law are permissible [39].

The legal status of a foreigner is not one-dimensional, but can be perceived on many levels, on the basis of multidisciplinary legal regulations [40]. In this paper, the status of a foreigner in a specific situation of applying for protection is important, regarding the right to health protection.

[3] In Poland, the Association for Legal Intervention participated in one of the earlier projects coordinated by Doctors of the World - in the HUMA network (Health for Undocumented Migrants and Asylum Seekers).

[4] Among numerous projects carried out by the International Organization for Migration in Europe, Equi-health is worth noting: Fostering Health Provision for Migrants, the Roma and Other Vulnerable Groups (2013-2016).

Poland – considered as a transit country, which is the first country in the European Union for which some of the refugees reach - does not belong to the countries that receive the most refugees (countries where the most applications for granting the refugee status are made). In 2016, the most applications were submitted in Germany (over 720,000), the United States (262,000) and Italy (123,000); the largest number of refugees, mainly from Syria, was adopted in 2016 in Turkey - 2.9 million people (IOM 2017). Asylum seekers in Poland are accommodated in 11 Centres for Foreigners, of which 4 are run by the Department of Social Assistance of the Office for Foreigners [41].

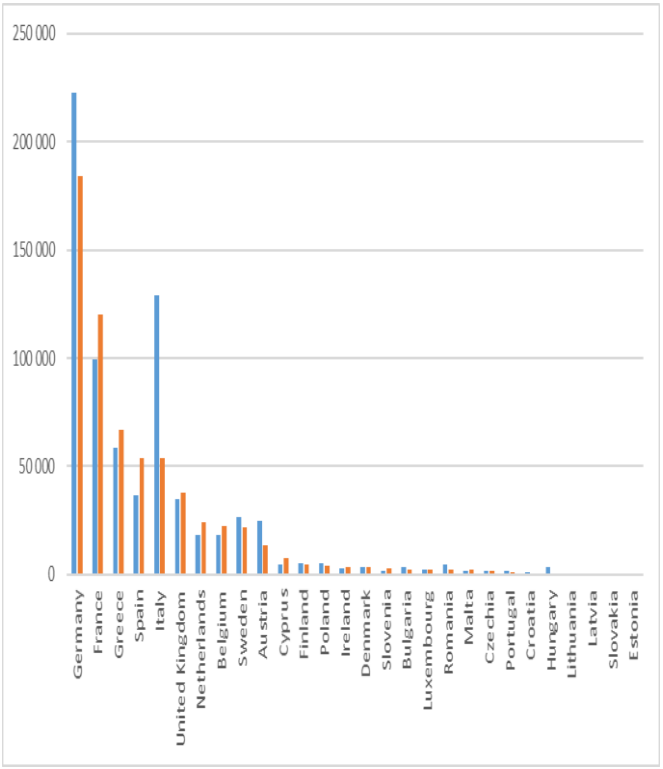

Figure 1. Asylum applicants in EU28 in 2017 and 2018 [42]

Pursuant to the Act on granting protection to foreigners on Polish territory [43], foreigners applying for refugee status (and persons acting on behalf of applicants) have the right to medical assistance, including healthcare services to the extent to which persons covered by compulsory or voluntary health insurance are entitled to to benefits under the Act of 27 August 2004 on health care services financed from public funds [44], excluding spa treatment or spa rehabilitation. Coordination of care is provided by the healthcare provider who concluded a contract with the Office for Foreigners (UCS); from 2015 it is Petra Medica Sp. z o.o. The care includes:

a. basic medical care: internist and pediatric;
b. psychological care;
c. diagnostic tests;
d. specialist medical care;
e. hospitalizations;
f. children's calendar vaccinations and additional vaccinations for adults;
g. specific procedures :
- Epidemiological Filter Program;
- Program for early detection of infectious diseases (including tuberculosis, hepatitis B and C, HIV carrier and people infected with venereal diseases);
- Program of Sanitary and Epidemiological Prevention Teams in outpatient clinics [41].

Once the international protection is given to a person, his or her new status is refugee. The 1951 Refugee Convention states that refugees should have access to health services equivalent to that of the host population. This protection is only given to persons who meet the criteria for refugee status. As health system financed from public funds is considered as inefficient in Poland, asylum seekers may have better access during the asylum procedure than later, having the refugee status. Further, due to existing barriers (different language, culture, lack of knowledge about the organisation of health system in the country etc.), refugees staying in Poland face similar problems as voluntary migrants.

VIII. IRREGULAR MIGRANTS

Irregular migrants stay in the country without legal basis, consequently, they have no access to health services provided – or financed - from the state (Office for Foreigners). Irregular migrants - according to previous research - use health care services to a lesser extent, while barriers in access to benefits are related to both the political situation and the organization of the health care system. and with the attitude of the person [45]. Although in Poland there is no legal obligation to report irregular immigrants to the police or any other institution, the fear of being reported may influence the decision of seeking medical help. In this group, delays in making decisions about health care contact are particularly visible, which in turn may lead to deterioration of health, epidemic outbreaks as well as to rising costs of care [46]. Although there is no reason to exclude irregular migrants from access to primary and specialised healthcare or pharmaceutical discounts [12], the scope of services is strongly limited: in Poland, migrants in an irregular situa-

tion have the right to receive emergency services (also during pregnancy), but there is no provision for non-emergency services or drug reimbursement. An exception applies to children who have the right to preventive services at school - if they are attending school. All other irregular migrants may benefit form the services offered by non-governmental, not-for-profit organisations.

IX. DISCUSSION

Since 2015, when the European migratory crisis started, several activities were undertaken in Europe for strengthening the accessibility and quality of healthcare services for asylum seekers and refugees. Some of them were focused on the large groups of refugees in refugees' camps and on the basic human rights, including the right to healthcare. Poland, being rather a transit country, does not suffer from the rapid influx of asylum seekers yet. On the contrary, the number of asylum seekers is decreasing. This is related to the political situation in Poland, to its geographical location as well as to the homogeneity of Polish population in the recent decades and to the attitudes of some groups of host population towards immigrants.

Still in 2013, the immigration to Poland was considered as relatively little politicised issue [47] however after the beginning of the migratory crisis and after the change of power the attitude of the new authorities changed dramatically. The concerns expressed by the government are reflected in the attitude of the population, with all its fears and prejudices as well as in the day-by-day practice of non-admitting asylum seekers on the borders. This does not make an easy start point for further discussions on the development of human rights for health for the "controversial" group of immigrants. Cultural barriers and attitudes towards asylum seekers and refugees might also influence the behaviour of medical and administrative staff as well as local authorities. However, it seems that local authorities make efforts to improve mentioned groups' accessibility to health care, by, for example, launching programmes providing appropriate information, in common with NGO's.

Entitlement to health care services in Poland depends on the status of a person. Emergency services are guaranteed for the broadest group of migrants, including irregular migrants. Asylum seekers, regardless of whether they stay in the Centre for Foreigners or outside, are entitled to the health services provided and coordinated by a healthcare unit which had signed an agreement with the office for Foreigners. Once given the refugee status, a person has rights to health services based on the same rules as Polish citizens, thus facing similar problems related to accessibility (waiting lists) plus barriers related to the lack of familiarity with the health system and culture.

International law upholds the rights that guarantee access to emergency services for refugees. There are no clear regulations indicating the need to cover this group with planned health care, both medical and preventive. EU countries decide on their own about the scope of health care rights of refugees and migrants. The question of what scope of access to health care should be considered as optimal is still open. Is it one that guarantees only access to emergency services and certain preventive measures or the equal rights to all publicly funded health services?

X.CONCLUSIONS

- The overall conditions are extremely important in ensuring accessibility to health care services for the particularly vulnerable groups of migrants, which are asylum seekers and refugees. Although mankind had developed several acts of international law guaranteeing, inter alia, the right to health care, the countries have adopted their own regulations related to the scope of services and official administrative procedures. The instability of political context may cause a change in the attitude of the authorities towards refugees in general, so the conditions of the access as well as the scope of services will depend in the political window in a given country.
- Due to its geopolitical location Poland, being the transit country with its specific approach to the refugees on the possible entry points, did not recorded the rapid increase in the number of immigrants seeking for international protection. Asylum seekers are granted access to health care services coordinated by a healthcare unit with had signed an agreement with the Office for Foreigners. Once the person receives the refugee status, his or her access to health services should be equivalent to that of the citizens of Poland. The situation may be different in case of a rapid grow of number of involuntary immigrants and then the problem may become more significant in the future.
- There are several structural and bureaucratic barriers that often depend on "institutional practice". One of the main problems is the non-admission of asylum seekers to Poland on the country border. Having no access to entry the country, they have no access to the

adequate health care and, in particular circumstances, their right to health may be not be respected.

- As for the cultural conditions, the diversity is one of the biggest challenges in the host country, requiring the proper education and attitude of medical and administrative staff as well as from the local population.

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